

00011901 (06/2011)

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DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL REGISTRAR COPY

RESIDENCE	1. NAME: FIRST MIDDLE LAST Ronald D. Smith		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	3A. DATE OF DEATH: MONTH DAY YEAR 12 05 2016	3B. HOUR: 10:02 p.m.
NCHS	4A. PLACE OF DEATH: (Check one) HOSPITAL DOA <input type="checkbox"/> ER <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> NURSING HOME <input checked="" type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify): <input type="checkbox"/>		4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR 08 16 2016		
4C	4C. NAME OF FACILITY: (If not facility, give address) St. Luke Health Services		4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN Oswego		4E. COUNTY OF DEATH: Oswego
4G	4F. MEDICAL RECORD NO.: A-7628		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES University Hospital Syracuse NY Onondaga Co		
	5. DATE OF BIRTH: MONTH DAY YEAR 05 17 1984		6A. AGE IN YEARS: 32 yrs.	6B. IF UNDER 1 YEAR ENTER: months days 05 17 1984	
	6C. IF UNDER 1 DAY ENTER: hours minutes 05 17 1984		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Oswego, NY		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
7A	8. SERVED IN U.S. ARMED FORCES? (Specify years) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano C <input type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify):		
7B	11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 <input type="checkbox"/> ≤ 8th grade 2 <input type="checkbox"/> 9th-12th grade; no diploma 3 <input checked="" type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate's degree 6 <input type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/Professional degree		10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese J <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan N <input type="checkbox"/> American Indian or Alaska Native (specify) P <input type="checkbox"/> Other Asian (specify) R <input type="checkbox"/> Other Pacific Islander (specify) S <input type="checkbox"/> Other (specify)		
	12. SOCIAL SECURITY NUMBER: 405-27-2111		13. MARITAL STATUS: NEVER MARRIED <input checked="" type="checkbox"/> 1 MARRIED <input type="checkbox"/> 2 WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/> 4 SEPARATED <input type="checkbox"/> 5		14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.
	15A. USUAL OCCUPATION: (Do not enter retired) Certified nurse's aide		15B. KIND OF BUSINESS OR INDUSTRY: Healthcare		15C. NAME AND LOCALITY OF COMPANY OR FIRM: Oswego NY St. Luke Health Services
81	16A. RESIDENCE: (State or Country if not USA) NY		16B. COUNTY or Region/Province If not USA: Oswego		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN Fulton
25	16D. STREET AND NUMBER OF RESIDENCE: 91 Kings Rd		16E. ZIP CODE: 13069		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF NO, SPECIFY TOWN: Volney
30	17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST David Smith		18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST Denise Atkinson		
31	19A. NAME OF INFORMANT: Denise Smith		19B. MAILING ADDRESS: (include zip code) 91 Kings Rd. Fulton, NY 13069		
31B	20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD 5 <input type="checkbox"/> DONATION 6 <input type="checkbox"/> ENTOMBMENT MONTH DAY YEAR 12 06 2016		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Traub Crematorium		20C. LOCATION: (City or town and state) Central Square NY
OR	21A. NAME AND ADDRESS OF FUNERAL HOME: Sugar & Scanlon Funeral Home 147 W. 4th St. Oswego NY 13126		21B. REGISTRATION NUMBER: 01642		
OS	22A. NAME OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon		22B. SIGNATURE OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon		22C. REGISTRATION NUMBER: 13496
QCOD	23A. SIGNATURE OF REGISTRAR: John A. Ford		23B. DATE FILED: MONTH DAY YEAR 12 06 2016		23C. SIGNATURE OF REGISTRAR: John A. Ford
CANDER	23D. DATE OF DEATH: MONTH DAY YEAR 12 05 2016		23E. SIGNATURE OF REGISTRAR: John A. Ford		23F. DATE OF DEATH: MONTH DAY YEAR 12 05 2016
	ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER				
	25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. Certifier's Name: Sandra A. Ford N.P. License No.: 330672 Signature: Sandra A. Ford Month Day Year 12 06 2016				
	25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month Day Year				
	25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Signature: Address: Month Day Year				
	26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year 08 16 2016 TO 12 05 2016				
	26B. Deceased last seen alive by attending physician: Month Day Year 12 05 2016				
	26C. Pronounced dead: Month Day Year 12 05 2016				
	27. MANNER OF DEATH: NATURAL CAUSE <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> 2 HOMICIDE <input type="checkbox"/> 3 SUICIDE <input type="checkbox"/> 4 UNDETERMINED CIRCUMSTANCES <input type="checkbox"/> 5 PENDING INVESTIGATION <input type="checkbox"/> 6				
	28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES				
	28A. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REFUSED				
	28B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES				
	30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) Respiratory arrest palliative care status minutes (B) AIDS 3 year (C)				
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Asymptomatic HIV Encephalopathy				
	31A. IF INJURY, DATE: MONTH DAY YEAR 2002 12 15		31B. INJURY LOCALITY: (City or town and county and state)		31C. DESCRIBE HOW INJURY OCCURRED:
	31D. PLACE OF INJURY:		31E. INJURY AT WORK? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		
	31F. IF TRANSPORTATION INJURY, SPECIFY: 1 <input type="checkbox"/> Driver/Operator 2 <input type="checkbox"/> Passenger 3 <input type="checkbox"/> Pedestrian 4 <input type="checkbox"/> OTHER (Specify):		32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		33A. IF FEMALE: 1 <input type="checkbox"/> Not pregnant within last year 2 <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death 3 <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death 4 <input type="checkbox"/> Unknown if pregnant within past year
	33B. DATE OF DELIVERY: MONTH DAY YEAR		33C. DID TOBACCO USE CONTRIBUTE TO DEATH? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES 1 <input type="checkbox"/> PROBABLY 2 <input type="checkbox"/> UNKNOWN		

For use by physician or registrar.

NAME OF DECEASED: **Smith, Ronald**DATE OF DEATH: **2002 12 15**TIME OF DEATH: **10:02 PM**

THIS IS TO CERTIFY that the foregoing is a
true and correct transcript of the DEATH
RECORD on file in the Office of the Registrar of VITAL
STATISTICS of the City of Oswego, New York, and of
the whole thereof.
WITNESS MY HAND AND SEAL OF THE
CITY OF OSWEGO, NEW YORK, this
20th day of October 20 17
Deborah A. Smith
REGISTRAR
City of Oswego, New York